Developed by Queensland Health, Townsville Hospital and Health Service

Queensland Government

Tuberculosis Non Contact Attendance Sheet

THHS Tuberculosis Service

TTH OUTPATIENT

URN: 867941

TARASYUK, IGAR NIK

1/56 MCILWRAITH STREET

SOUTH TOWNSVILLE QLD 4810

MC: 2689626652 1 10/2019

DOS: 15-JUN-2018 09:30

FIN: APP2468293

MALE

DOB: 25-NOV-1988

(H) 0439368316

(M) 0439368316

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Personal information collected by the Townsville Hospital and Health Service is handled in accordance with the *Information Privacy Act 2009* and other relevant legislation. The Townsville Hospital and Health Service is collecting your information in accordance with the *Information Privacy Act 2009* in order to provide you with health and other support services.

All personal information will be securely stored and only accessible by designated staff. Your health and personal information may be given to other health care providers for the purpose of ongoing treatment. Your personal information will not be disclosed to agencies that are not involved in your care without your authority, unless required by law.

For information about how the Townsville Hospital and Health Service is protects your personal information, or to learn about your right to access your personal information, please see our website at www.health.qld.gov.au or www.health.qld.gov.au/townsville/About/publications/right-to-information.asp

Patient Details

Phone (H) 0 (M) 0439 368 316

Country of birth BELARUS Main language spoken English

If born overseas, date of arrival in Australia 10/01/2001 Years spent in Australia 18 Years spent in country of birth 6

Indigenous status:
- ☐ Aboriginal but not Torres Strait Islander Origin
- ☐ Torres Strait Islander but not Aboriginal Origin
- ☐ Both Aboriginal and Torres Strait Islander Origin
- ☐ Neither Aboriginal nor Torres Strait Islander Origin
- ☐ Australian South Sea Islander
- ☐ Not Stated/Unknown

Parent/Guardian Details (if <16 years of age)

Name ..... Relationship (i.e. mother, father, guardian) .....

Address ..... Phone (H) ..... (M) .....

TB Contact History

Which countries have you lived or travelled in BELARUS, NEW ZEALAND, UNITED STATES, JAPAN, SINGAPORE, GERMANY, FRANCE, MALAYSIA

When did you have your last chest x-ray & where Date ... / ... / ... Where ... ☑ N/A

Have you ever worked in the health care industry: ☐ No ☑ Yes In what capacity DOCTOR/STUDENT (Intern) For how many years 2

Have you ever been involved in the care of patient/s with TB: ☑ No ☐ Yes

Have you ever been in contact with a person who has TB: ☑ No ☐ Yes

If *Yes*, Name of person ..... When and where .....

Have you ever had TB in the past: ☑ No ☐ Yes

If *Yes*, When and where ..... Were you treated: ☐ No ☐ Yes How long was the treatment .....

Have you ever had a skin test (Mantoux) or blood test for TB: ☑ No ☐ Yes

If *Yes*, When ..... Result ..... Reason for today's test Employment

Medical History

Do you have any of the following symptoms (tick and provide description)?

☐ Cough .....

☐ Fevers .....

☐ Recent weight loss ..... NIL

Have you had a viral illness in the last four weeks: ☑ No ☐ Yes .....

Have you had any vaccinations within the last four weeks: ☑ No ☐ Yes .....

Do you have any medical conditions: ☑ No ☐ Yes .....

Are you currently taking any medications: ☑ No ☐ Yes .....

Do you have any allergies: ☑ No ☐ Yes .....

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TUBERCULOSIS NON CONTACT ATTENDANCE SHEET

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Tuberculin (Mantoux) Test Consent

- I have received Fact Sheets about Tuberculosis (TB) and the Tuberculin (Mantoux) Test in a language which I understand. An interpreter service/cultural support person was provided as requested by me.
- I was given the opportunity to ask questions about the Tuberculin (Mantoux) Test. Any questions asked have been answered to my satisfaction.
- I understand the details of the Tuberculin (Mantoux) Test.
- I agree to return in 3 days for reading (unless otherwise arranged with TB nurse)

I consent to the administration of the Tuberculin (Mantoux) Test.

Name of patient: IGAR TARASYUK.

Name of parent/guardian/substitute decision maker

(under Powers of Attorney Act 1998 or Guardianship Administration Act 2000):

.....

Signature: .....

Date: 15/06/2018

BCG Vaccination Consent

- I have received Fact Sheets about Tuberculosis (TB) and BCG Vaccination in a language which I understand. An interpreter service/cultural support person was provided as requested by me.
- I was given the opportunity to ask questions about BCG Vaccination. Any questions asked have been answered to my satisfaction.
- I have responded to questions in the BCG Vaccination Fact Sheet.
- I understand the details of the BCG Vaccination, the risks of the vaccination (including any significant problems which are specific to me) and the likely outcomes if those risks occur.

I consent to the administration of the BCG Vaccination.

Name of patient: .....

Name of parent/guardian/substitute decision maker

(under Powers of Attorney Act 1998 or Guardianship Administration Act 2000):

.....

Signature: .....

Date: ..... / ..... / .....

Office Use Only

BCG history: ☑ Yes ..... / ..... / ....Baby ☐ No ☐ Unknown

BCG Scar: ☑ Present ☐ Absent ☐ Unknown ☐ Doubtful

	Initial Test	2 step	BCG	Comments
Date	15/6/18			
Batch No.	C5037AB			
Dose	0.1ml			
Signature				
Venue	TTH			
Read Date	18/6/18		☐ Declined	
Result LH	18 mm		☐ Later date	
Signature			☐ Not required	
Venue	TTH		☐ Contraindicated	
IGRA				

Outcome

- ☐ 2 step
- ☐ Mx not required
- ☑ CXR required
  Form given 18/6/18
- ☐ Significant Mx
- ☐ Result letter required/given
- ☐ MO appt ...../...../.....
- ☐ FTA ☐ LTFU
- ☐ DNR ☐ NFA/File away

- ☐ CXR required
  Form given ...../...../.....
- ☐ Significant Mx
- ☐ Result letter required/given
- ☐ MO appt ...../...../.....
- ☐ FTA ☐ LTFU
- ☐ DNR ☐ NFA/File away

Post Initial MO outcome

- ☐ Further MO
- ☐ CXR Program
- ☐ CP
- ☐ XRO@ .....
- ☐ Discharged
- ☐ Sputum
- ☐ FTA/LTFU
- ☐ Chest x-ray surveilance as per protocol

- ☑ HBCIS entered
- ☑ Database entered
- ☑ Finalised, send to ieMR

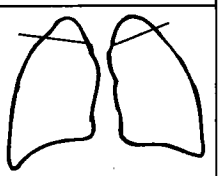
Signature: .....

Date: ..... / ..... / .....

Xray attendance no. 8195120 **Date:** 18/6/18

Chest Xray Result	Outcome	When	CXR Program
☑ Normal	CXR Program		Initial
☐ Abnormal TB	MO appointment	~~6/12~~	6/12 Due:
☐ Abnormal Non TB	Referred GP/Specialist		18/12 Due:
☐ Radiologist report sighted	Further Xray review		2 years Due:
	No follow up		

Comments



Signature RNB

Date 20/6/18

Xray attendance no. **Date:**

Chest Xray Result	Outcome	When	CXR Program
☐ Normal	CXR Program		Initial
☐ Abnormal TB	MO appointment		6/12 Due:
☐ Abnormal Non TB	Referred GP/Specialist		18/12 Due:
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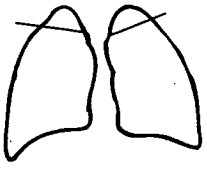

Signature .....

Date ..... / ..... / .....

email to QH email sent 4/7/18 C.O.

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